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ABSTRACT

In 1988, Franklin County (Ohio) Children Services (FCCS) initiated the development of a bi-level, community-based, multi-disciplinary process to review all deaths of children in its open caseload, as well as child deaths in families with which FCCS had contact in the previous 12 months. This report examines the work of the Deceased Child Review Team during 1992, when 207 child deaths were investigated, 58 of which were of children with prior or continuing contact with FCCS. The report notes that cause of death was determined in 200 cases, with the largest number, 85, being cases of perinatal death due to extreme prematurity. The second leading cause of death was Sudden Infant Death Syndrome (SIDS), which accounted for 31 deaths. Child deaths tended to be clustered in Columbus, the largest city in the county, and black children had a higher death rate than white children. Of 31 FCCS cases subjected to further investigation, maltreatment was confirmed as the cause of death in 3 cases, while maltreatment was suspected in 5 others. The report includes various tables and charts presenting demographic data about the child deaths in the county. Seven appendixes provide tabular data about child deaths in Franklin County from 1989 through 1992 and information about the FCCS Deceased Child Review System. (MDM)

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Executive Summary

During 1992, the Franklin County Deceased Child Review Team, consisting of 21 local child-serving systems, continued their efforts toward a better community understanding of why children die, with the ultimate goal being elimination of preventable child deaths. This fifth Annual Report of the Franklin County Deceased Child Review System presents 1992 statistical findings, accomplishments and priorities and action planning for 1993.

Total County Deaths

A total of 207 Franklin County children died in 1992; causes could be determined in 200 instances. As in the past three years, the largest proportion of children died during the perinatal (at or near birth) period. A total of 85 children (41%) died during this period, most from extreme prematurity, with 26 also exhibiting serious congenital defects at birth. The second leading cause of death was Sudden Infant Death Syndrome (SIDS), which accounted for 31 deaths, the same number as in 1991. Illness caused 26 deaths, as did unintentional injuries (previously called accidents), 11 of which resulted from traffic accidents. Seventeen children (all over 28 days of age) died as a result of congenital defects. Homicides totaled 11, down from 18 in 1991 (-39%). There were four suicides in 1992.

Geographically, the proportional distribution of child deaths in 1992 again tended to be clustered around the central city area. Of 203 known home addresses, 64 child deaths (32%) occurred in the relatively small Franklin County Children Services (FCCS) North and South service regions. This compares with a 39% proportion in 1991, 35% in 1990 and 43% in 1989.

In comparison, the child populations of these regions comprise only 23% of the total Franklin County child population. Proportionately, the South and North Regions have more Black children (comprising 65% and 44% of their total child population) than the other two regions. Since the proportion of Black children in poverty is also higher than that of the total population, the proportion of Blacks in the population varies directly with the regional death rates. The higher the proportion of Black population, the higher the death rate.

Also, in comparing service regions on the basis of per capita (individual) income, South Region is the lowest and North Region is second lowest. In the 1992 evaluation of deceased children determined to be from low-income families, 74 (36%) met this criterion. North and South Regions have proportionately higher numbers of deceased children coming from low-income families—46% in North Region and 41% in South Region. Economically, North and South Regions also

have a much lower per capita level of income than the rest of the county. Although not as pronounced as in 1991, the death rate per region is inversely proportional to the per capita level of income—the lower the income level, the higher the child death rate.

Maltreatment (abuse or neglect perpetrated by a parent/caretaker contributed to or was suspected to have contributed to the child's death) was again evaluated for the total 207 child deaths in 1992. Maltreatment was confirmed in seven deaths (3%)—down from nine (-22%) in 1991. Suspected maltreatment was found in an additional 2% of the deaths (5 of the total 207), down from 8% in 1991.

Child Deaths Meeting Review Criteria

In 1992, FCCS again reviewed all deaths of children on its caseload at the time of death, as well as children who had been investigated or on "open case status" within a twelve month period prior to the death. Overall, 58 children (28%) of the 207 children who died in 1992 (or their families) had some kind of contact with FCCS prior to death. This compares with 59 children (27%) in 1991, 45 children (18%) in 1990 and 56 children (27%) in 1989.

It should be noted that the number of children with whom FCCS has direct contact has consistently risen every year since 1989. In 1992, FCCS had contact with 22,056 children compared with 19,504 in 1991 (a 13% increase). In 1990, the number of children having direct contact with FCCS totaled 16,915 and in 1989, 15,986.

Of the 58 children, 13 of the children (or their families) (6%) were open cases or under investigation at the time of death. An additional 18 children (or their families) (9%) had some kind of contact with FCCS within a year of death, for a total of 31 children who were eligible for review.

Of the 31 child deaths eligible for review, eight were formally staffed with the participation of all FCCS and community agency direct service providers working with the child/family proximal to the death. Case summary reports or record reviews were completed for the remaining twenty-three deaths. All of these deaths were reviewed by the Team death certificate review sub-committee with additional information being collected. Major issues identified regarding these deaths as a result of the death certificate review process were addressed with the entire Team in regular monthly meetings.

Seventeen of the 31 deaths eligible for review involved infants (< 1 year). Ten of these occurred during the perinatal period, resulting from extreme prematurity and/or congenital defects. Mothers of seven of the 10 infants (six mothers) also had prior history of substance abuse. One of the infants was drug addicted at

birth and two had older siblings who had been born drug addicted. All three SIDS deaths were infants, including one born to a minor mother. Four infants died as a result of illness, one had been cocaine addicted at birth and died of a pulmonary hemorrhage. The three remaining children died of bronchial problems, including one who had not received adequate post-natal care after a premature birth.

The remaining 14 deaths involved children over the age of one year. Eight of these deaths resulted from unintentional injury and included two aspirations, two auto accidents, two pedestrian/traffic fatalities, one scald burn, and one electrocution. Four deaths resulted from long-term congenital complications, one resulted from illness (cancer) and one from suicide.

Maltreatment was confirmed in three of the 31 deaths meeting the review criteria. These included two unintentional injuries (a child scalded in the bathtub by a sibling and a child run over by another child when both were left unattended in a running vehicle) and one illness (an infant dying of bronchiolitis who had not received adequate medical care after a premature birth). Maltreatment was suspected in five additional deaths, which included three occurring in the perinatal period, one illness and one suicide.

1992 Team Accomplishments

A strong and viable partnership on behalf of eliminating preventable child deaths and improving systems serving children and families continues to exist in Franklin County. Following are some of the accomplishments generated in part by the Franklin County Deceased Child Review System:

- Expansion of the number of professionals and child-serving systems involved with the Team to include a representative from the Franklin County Department of Mental Retardation and Developmental Disabilities.

- FCCS funding of eight prevention grants to local agencies which specifically address the needs of high-risk infants and their families.

- Institution of a process whereby all deaths can be reviewed via a sub-committee reviewing death certificates and screening out those not requiring further discussion by the total Team.

- Modification and revision of data information forms for use by the sub-committee in reviewing all child deaths.

- Continuation of collaborative efforts by FCCS, Columbus Health Department and Grant Hospital on the Great Start project which assesses

the risk status of infants at birth and refers them for appropriate services.

- Provision of expert testimony to the legislature and Public Children's Association of Ohio regarding the need for legislation mandating the child death review process.

- Presentations by Team members at several local and national conferences, providing exposure for the review process and its focus on coordinated community efforts to improve systems impact regarding children and their families.

Action Planning for 1993

The following areas are targeted for action in 1993:

- Assure the availability of prenatal care for all women, including the following components: 1) early and continuing risk assessment; 2) health promotion; and 3) medical, nutritional, and psychosocial interventions and follow-up (Source: Healthy People 2000: National Health Promotion and Disease Prevention Objectives, U.S. Department of Health and Human Services, U.S. Public Health Service, 1990).

- Continue collaboration by involved systems and agencies to provide a more comprehensive system of care for at-risk pregnant women with substance abuse issues.

- Institute and expand outreach and lay home visiting programs to pregnant women, particularly in the central city area.

- Develop and/or expand community-based programs to provide the services necessary to assure healthy pregnancy outcomes and childhoods for all children in these communities.

- Promote the expansion of women and child health services and issues through legislative advocacy.

- Institutionalize efforts targeted at the elimination of preventable childhood injury and death in currently operating systems and programs.

Key Statistics

REPORT ON CHILD DEATHS IN 1992

Child Deaths:	207	Total
Cause of Death:	85	Perinatal (41%)
	17	Congenital (8%)
	31	SIDS (15%)
	26	Illness (13%)
	26	Unintentional Injury (13%)
	11	Homicide (5%)
	4	Suicide (2%)
	7	Unknown (3%)
Age Ranges:	85	< 28 days (41%)
	58	28 days to 1 year (28%)
	17	1 to 5 years (8%)
	11	5 to 10 years (5%)
	10	10 to 14 years (5%)
	25	14 to 18 years (12 %)
	1	Unknown (1%)
Sex:	129	Male (62%)
	78	Female (38%)
Race:	138	White (67%)
	60	Black (29%)
	4	Other (2%)
	5	Unknown (2%)
Demographics:	37	North (18%)
	27	South (13%)
	60	East (29%)
	79	West (38%)
	4	Unknown (2%)
Maltreatment	7	Confirmed (3%)
	5	Suspected (2%)
	182	None (89%)
	13	Unknown (6%)

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Foreword

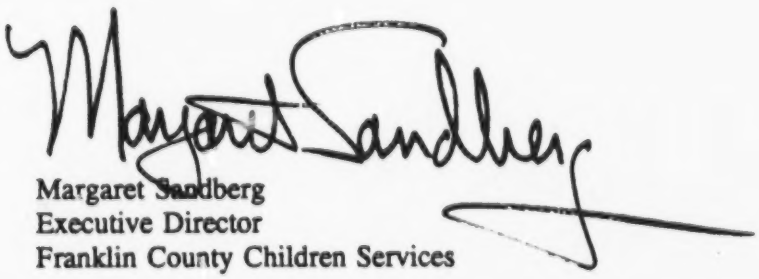
The Franklin County Deceased Child Review Team began in 1988 with strong multi-system support which continues to date. Team members now include representatives from 21 child-serving systems throughout the community. Representation from the Mental Retardation and Developmental Disabilities Board occurred during 1992.

The continued commitment of Team members to the review process has been crucial to its continued development and success toward the identified mission of elimination of preventable child deaths. They are to be commended for making this process valuable to the community, particularly given the often frustrating and painful nature of the reviews.

Many thanks are extended to the line staff of various agencies and systems who participated in the first-level staffings. Their involvement in the review process is invaluable, as they are the ones who initially examine the details of individual child deaths, making recommendations designed to improve direct service which ultimately impacts systems.

Efforts were made to review **all** child deaths in 1992 via a death certificate review process. Although this goal was not realized, recommendations have been made for modification, improvement and streamlining of the death certificate review process for use in 1993. The sub-committee consisting of representatives from Central Ohio SIDS, Children's Hospital, Columbus Health Department, Columbus Police Department, Franklin County Coroner's Office and Franklin County Children Services is to be graciously thanked for their time and effort in the improvement of this process.

Finally, special thanks to Rick Morris for his support of this program, to Pamela Schirner for coordinating and maintaining the on-going work of the review process and to Harry Griggs for maintaining the database and producing graphics contained in this report.



Margaret Sandberg
Executive Director
Franklin County Children Services

Introduction

In 1988, Franklin County Children Services (FCCS) initiated the development of a bi-level, community-based, multi-disciplinary process to review all deaths of children on its open caseload, as well as deaths where the Agency had contact with the child/family in the twelve months preceding death. 1992 marked the fifth year of operations for the Franklin County Deceased Child Review System.

With strong support and involvement of 21 other local child serving systems, FCCS maintains a review process which enables the community to identify systems problems and deficits related to child deaths and to work collaboratively to resolve identified issues and thereby eliminate preventable child deaths, not just those attributed to maltreatment.

The review process also identifies and tracks causal trends in the deaths of children which helps prioritize, link and focus community resources when expedient and to develop program initiatives designed to impact on top priority problem areas. See Appendix F for a description of the review process.

The review process recognizes and affirms good practice, programs and standards and is an excellent tool for ensuring that issues related to child death are reviewed in a systematic and timely manner. It is only by reviewing "worst case" situations that we are able to identify issues and work to make necessary changes throughout the entire child-serving community.

Two key principles underlie the deceased child review process:

- Child death is a community-wide issue and concern—not just that of child protective service agencies.

- Prevention of future deaths through quality enhancement of services, programs and systems is the desired result from the review process—not negative sanctions against individuals or agencies. Separate, existing procedures are used to determine if disciplinary or other punitive actions are warranted in particular instances of child deaths.

Key results obtained after five years of use are:

- An established, consistent process for review of child deaths for both agency staff and the community. The community is assured that the collective results of these reviews are made public periodically.

- Specific program and systems changes designed to reduce preventable child deaths.

- Strong multi-agency support for the review process, resulting in improved community planning and programs.

- Comprehensive data available for use in planning and refining the county child-serving system.

- Public education so that families are more aware of child safety issues and needs.

This report details the Franklin County Deceased Child Review System's fifth year findings and presents a comparative analysis of child deaths since 1989. Figures from 1988 are not included as the data are not considered reliable.

Please note that several modifications were made in data reporting in 1992. Deaths occurring in the perinatal period are no longer combined with deaths resulting from congenital defects **unless** the child is less than 28 days of age. For data display purposes, congenital deaths are combined with those resulting from illness. Data in this report from 1989, 1990 and 1991 have been similarly adjusted. Previous reports should not be used for comparison due to these modifications.

Total County Deaths

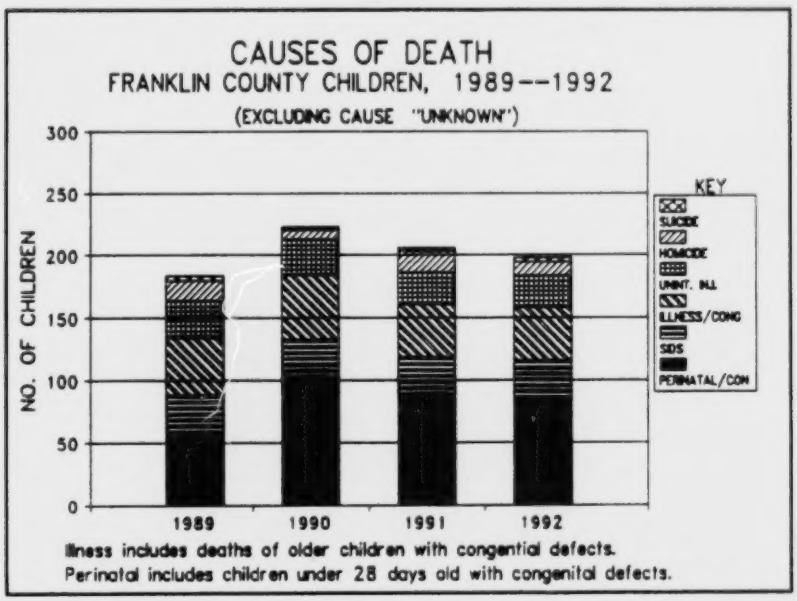
Overview

A total of 207 Franklin County children (age 17 or under) died in 1992. This compares to 221 child deaths in 1991, a decrease of 6 percent. Out of a total county child population of 236,766 (1990 U.S. Census), the 1992 child death rate was 8.7 per 10,000 children. Excluding infants (children under 1 year of age), whose death rate is based on the number of live births, the county death rate for children age 1 and over was 2.9 per 10,000 (65 deaths out of a population of 223,170). This compares to a rate of 3.4 per 10,000 for this age group in 1991.

Of the 207 deaths, the cause of death could be determined in 200 instances. As in 1990 and 1991, the largest proportion of children died during the perinatal (at or near birth) period (Figure 1). A total of 85 children (41%) died due to these causes. Twenty six of these children also exhibited congenital complications at birth. The second leading cause of death was Sudden Infant Death Syndrome (SIDS), which accounted for 31 deaths. Illness caused 26 deaths. Seventeen children died from congenital defects. (These are included with the illness deaths in the chart below). Unintentional injuries also totaled 26 (11 of which resulted from traffic accidents). Homicides totaled 11, down from 18 in 1991 (-39%). There were four suicides in 1992.

Thirty-one of the deaths met the criteria for review by the County Team, down from 44 in 1991. These deaths will be discussed later in the report.

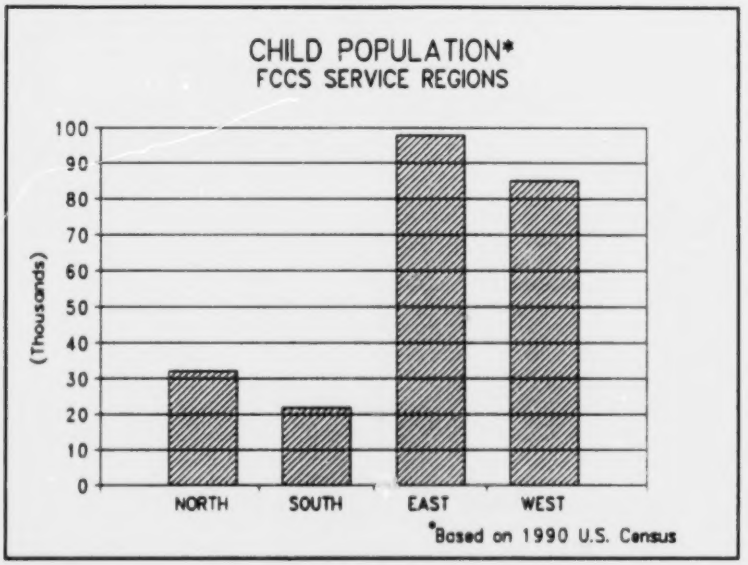
Figure 1



Geographic and Demographic Factors

The proportional distribution of child deaths in 1992, as in 1990 and 1991, tended to be clustered around the central city area. Out of 203 known home addresses, 64 child deaths (32%) occurred in the relatively small North and South FCCS service regions. In 1991, however, the proportion was 39%. In comparison, the child populations of North and South Regions comprise only 23% of the total Franklin County child population—53,980 out of the total county population of 236,766. These two regions, which basically surround the central city, are bounded on the north by Morse Road, on the south by Refugee Rd., on the west by the Olentangy and Scioto Rivers, and on the east by Alum Creek.

Figure 2

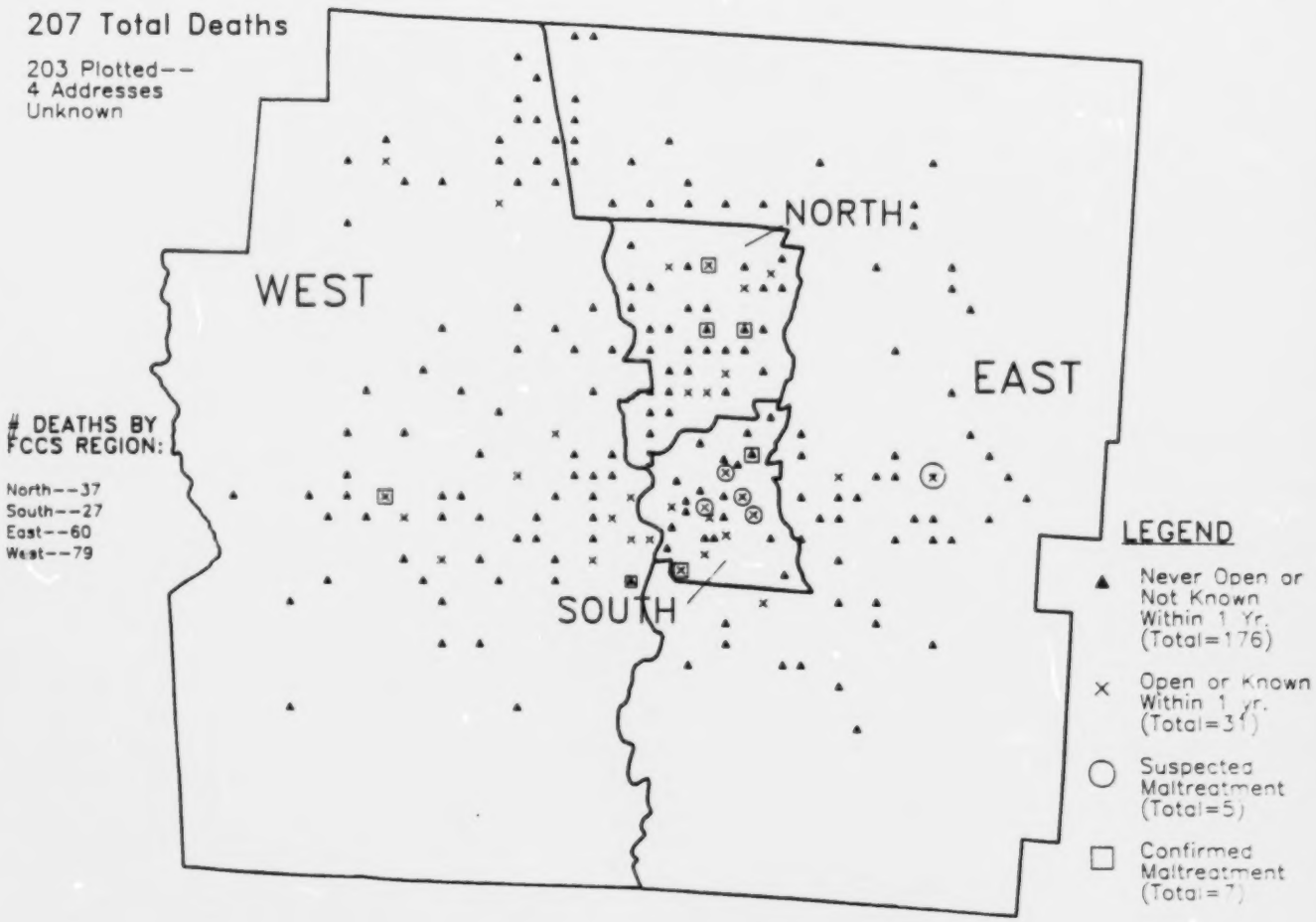


Based on the smaller number of child deaths eligible for review, the disparities between regions are even more pronounced. Of the 31 deaths in this category, 16 (52%) occurred in North and South Regions. Seven occurred in North Region, nine in South Region, three in East Region, and twelve in West Region. The map on the next page plots the geographic distribution of deceased children known to FCCS within a year of death with the remainder of the deceased child population.

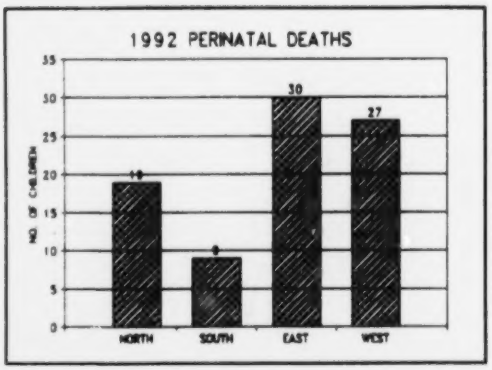
West Region had a disproportional number of child deaths in 1992 due to SIDS and illness/congenital defects—18 and 19, respectively. This amounts to 58 percent of all SIDS deaths and 44 percent of all illness/congenital deaths. This Region has about 36 percent of the Franklin County child population (84,998 of the total of 236,766 children). West Region also had the highest number of SIDS deaths in 1991—13 of the 33 total. The following charts depict child death causes for each FCCS service region.

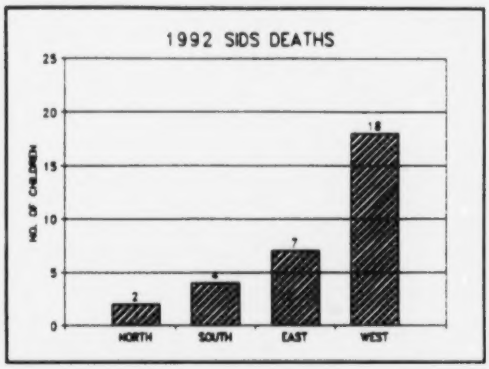
GEOGRAPHIC DISTRIBUTION
1992 CHILD DEATHS

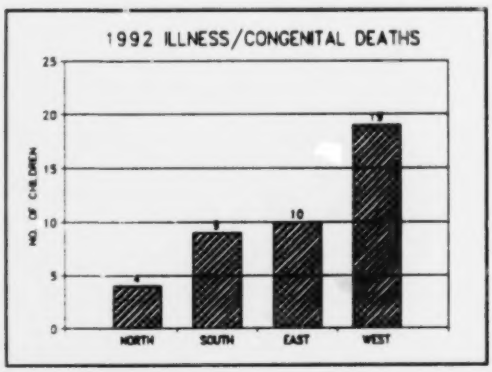
FRANKLIN COUNTY, OHIO

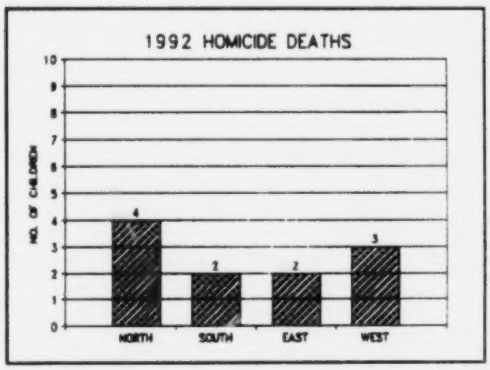


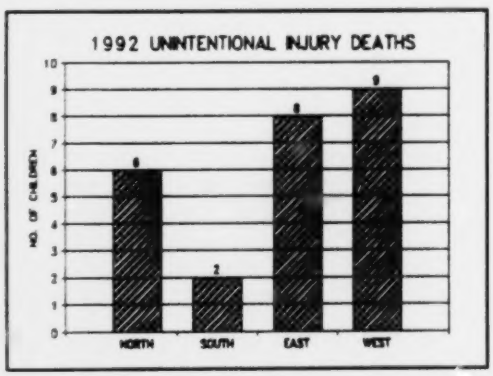
1992 CHILD DEATH CAUSES BY FCCS SERVICE REGION

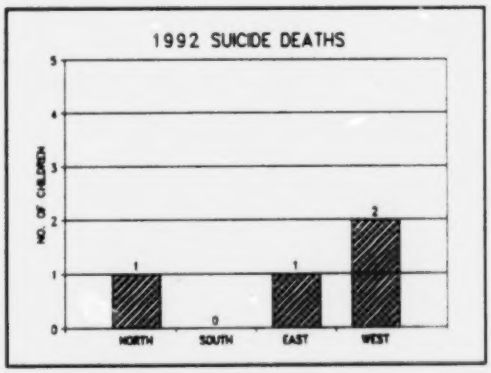






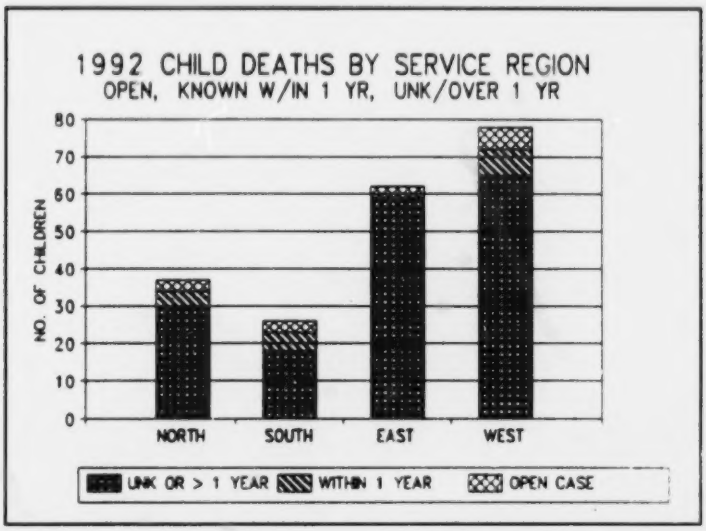






The proportion of total child deaths in South Region which were in cases either open or known within a year to FCCS was higher than for the rest of the county. Nine of the 27 children who died in South Region (33%) were open or known within a year of death (four open, five within one year). This proportion is, however, lower than last year's figure of 52%. Seven of the 37 children from North Region (19%) were open/known to FCCS within one year (three open, four within one year). In East Region only three of 60 children (5%) were open/known within a year (two open, one within one year). In West Region the figure was 15% (12 out of 79 children—five open, seven within one year).

Figure 3



Economic/Racial Factors

Although the absolute populations of North and South Regions are low, it should be noted that physically they are small areas, and that their population densities are likely higher than the remainder of the county's. Density/crowding may partly lie behind the larger number of child deaths occurring in these regions. But location alone probably does not explain the higher proportions of children dying around the central city area. Not only are North and South's death rates high in proportion to their population compared to the rest of the county, but also their income levels are vastly different.

As a measure of low income, the number of deceased children from families receiving Public Assistance was again examined in 1992. Low income was defined as a family/child eligible for and/or receiving Medicaid, or receiving food stamps for at least one month of the year. Seventy-four of the 207 children (36%) met this criteria (last year the figure was 35%). North and South Regions

have proportionately higher numbers of deceased children coming from low-income families—46% of the deceased children in North Region were low-income, 41% of the children in South Region were low income.

Figure 4 below compares the regions on the basis of per capita income as obtained from the 1990 U.S. Census. South Region is the lowest with an average income of $9,595 per person. North is second lowest at $10,766 per capita. East Region is the highest at $16,294 while West is second highest with a per capita income of $14,918.

Figure 4

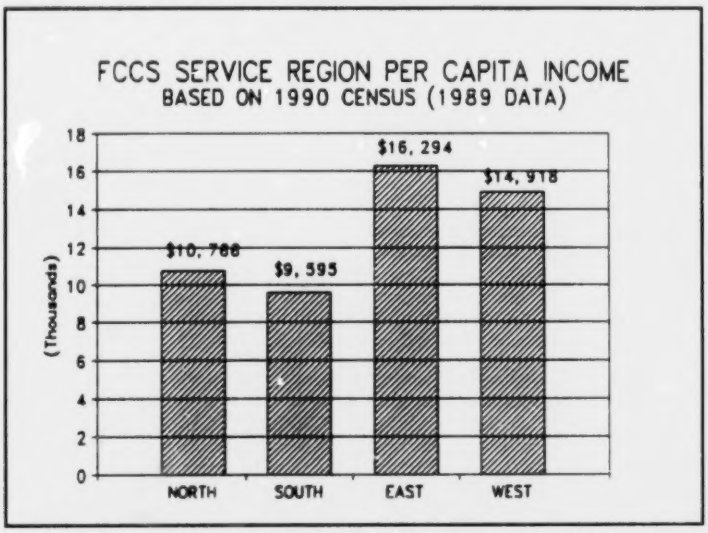
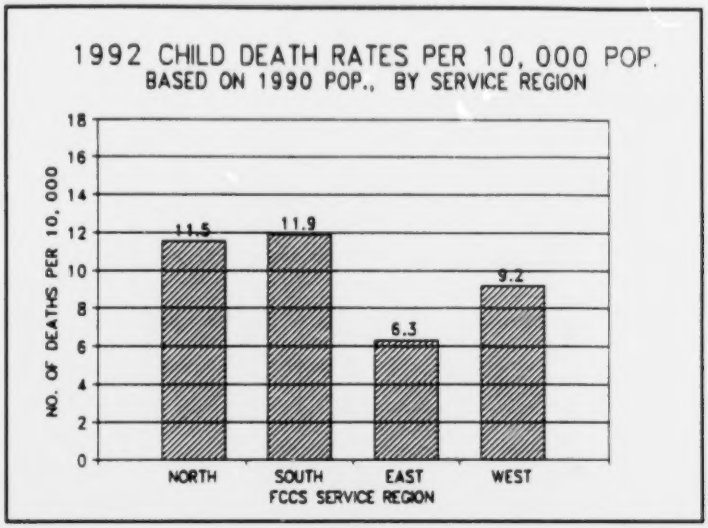


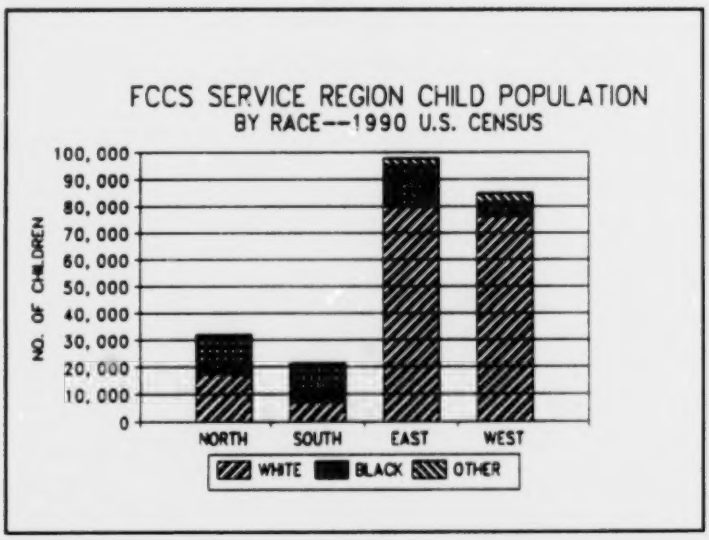
Figure 5 (next page) shows the death rate per region in comparison to overall child populations. **The child death rate per region is inversely proportional to the per capita level of income—the lower the income level, the higher the child death rate.** However, this relationship is not as pronounced as in 1991, when North and South had death rates of 14.3 and 15.1 per 10,000 population, respectively.

Figure 5



As Figure 6 shows, South Region has proportionally many more Black children than the other regions. South's Black child population comprises 65% of its total child population. This compares to 44% in North Region, 16% in East, and 7% in West. Since the proportion of Black children in poverty is higher than that of the total population, the proportion of Blacks in the population varies directly with the regional death rates shown in Figure 5 above. **The higher the proportion of Black population, the higher the death rate.**

Figure 6



Findings by Cause of Death

Perinatal

- **There were 85 deaths occurring in the perinatal period in 1992, the same as in 1991.**
- **Of these 85, 26 also exhibited congenital defects at birth.**
- **47 (55%) were female and 38 (45%) were male.**
- **57 (67%) were White and 28 (33%) were Black.**
- **Age Range:**

  All 85 children were less than 28 days old.

Most of the deaths resulted from extreme prematurity. Five of these children were open cases at the time of death. Ten others (or their families) had been known by FCCS within one year prior to death.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Known Within 1 Year	3	3	1	3
Never Known or > 1 Yr	16	6	29	24
Total	19	9	30	27

There was suspected maltreatment in three of the perinatal deaths—all known to FCCS within one year. Seventeen of these children (20%) were from low-income families.

Sudden Infant Death Syndrome

- **There were 31 SIDS deaths in 1992, down from 33 in 1991.**
- **18 (58%) were male and 13 (42%) were female.**
- **8 (26%) were Black and 23 (74%) were White.**
- **Age Range:**

< 6 months	29
6-12 months	2

One of the children who died of SIDS was on an open case at the time of death. Two others (or their families) had been known within one year of death.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Known Within 1 Year	0	0	0	3
Never Known or > 1 Yr	2	4	7	15
Total	2	4	7	18

It is unclear why so many (58% of the total) of the SIDS deaths occurred in West Region. In 1991, West also had the highest number of SIDS deaths (13 of the total of 33).

Maltreatment was not found in any of the SIDS deaths, but fifteen of the children (48%) came from low-income families.

Illness

- **There were 26 child deaths due to illness in 1992, exactly the same as in 1991.**
- **10 (38%) were male and 16 (62%) were female.**
- **9 (35%) were Black and 17 (65%) were White.**
- **Age Range:**

< 1 year	13
1-5 years	6
5-10 years	2
10-14 years	2
14-18 years	3

Two children who died of illness were open on the FCCS caseload at the time of death. Three others had been known to FCCS within one year of death.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Known Within 1 Year	1	4	0	0
Never Known or > 1 Yr	2	4	5	10
Total	3	8	5	10

Two of the illness deaths (one of which was eligible for review) were confirmed as maltreatment. Another, also eligible for review, was deemed suspected maltreatment. Twelve of the children who died from illness were from low-income families.

Unintentional Injuries

- **There were 26 deaths resulting from unintentional injuries (accidents), the same as 1991.**
- **22 (85%) were male and 4 (15%) were female.**
- **4 (15%) were Black, 20 (77%) White, 1 Biracial (4%), and 1 of unknown race.**
- **Age Range:**

< 1 year	2
1-5 years	6
5-10 years	5
10-14 years	2
14-18 years	10
Unknown	1

Four of these deaths were of children on open cases. An additional four children had been in contact with FCCS within a year of death.

Geographic Location of Deaths by Region					
	North	**South**	**East**	**West**	**Unk**
Known Within 1 Year	3	1	1	3	0
Never Known or > 1 Yr	3	1	7	6	1
Total	6	2	8	9	1

Twelve of the 26 unintentional injury deaths (46%) were due to traffic accidents (including one bicyclist struck by vehicle). Causes of unintentional injury deaths are as follows:

- **12 traffic accidents**
- **4 asphyxiations/chokings**
- **2 house fires**
- **2 electrocutions**
- **2 shootings by others**
- **1 shooting by self**
- **1 drowning**
- **1 pneumonia due to "thermal injuries"**

- **1 head injury suffered during birth**

Two of the injury deaths were confirmed as maltreatment. Both were eligible for review. One child was in an automobile left running by another child's mother; the mother's child backed over the deceased child. The other maltreatment involved a child opened with FCCS as a result of being scalded in the bathtub. The child later died of pneumonia.

Ten of the children who died from injuries (38%) were on public assistance.

Congenital

- **17 children over the age of 28 days died from congenital conditions.**
- **9 (53%) were male and 8 (47%) were female.**
- **10 (59%) were White, 3 ((18%) Black, 1 (6%) American Indian, and the race of 3 children was unknown.**
- **Age Range:**

< 1 year	6
1-5 years	3
5-10 years	3
10-14 years	2
14-18 years	3

Two of these children were on open cases at the time of death. An additional two children had been known to FCCS within one year.

Geographic Location of Deaths by Region					
	North	**South**	**East**	**West**	**Unk**
Known Within 1 Year	0	1	0	3	0
Never Known or > 1 Yr	1	0	5	6	1
Total	1	1	5	9	1

None of congenital disorder deaths was identified as maltreatment. Nine of the children (53%) were from families on public assistance.

Homicides

- **There were 11 homicides in 1992, down from 18 (-39%) in 1991.**
- **9 (82%) were male and 2 (18%) were female.**
- **7 (64%) were Black and 4 (36%) were White.**
- **Age Range:**

< 1 year	2
1-5 years	1
5-10 years	1
10-14 years	0
14-18 years	7

None of these children was on an open case at the time of death. Neither had any been known to FCCS within one year of death.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Known Within 1 Year	0	0	0	0
Never Known or > 1 Yr	4	2	2	3
Total	4	2	2	3

Eight (73%) of the homicides resulted from shootings. Two were stabbings and one death resulted from a beating.

Six (55%) of the children's families were determined to be low-income (eligible for public assistance). Three (27%) of the homicide deaths—two shootings and the beating—were identified as confirmed maltreatment.

Suicides

- **There were 4 suicides in 1992, the same as in 1991.**
- **Two were male and two were female.**
- **1 was Black and 3 were White.**
- **Age Range:**

10-14 years	2
14-18 years	2

One of the suicides had been known to FCCS within one year of death.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Known Within 1 Year	0	0	1	0
Never Known or > 1 Yr	1	0	0	2
Total	1	0	1	2

One of the children, known to FCCS within one year, was a determined to have elements of suspected maltreatment due to a history of questionable follow-through with recommended services.

Three of the suicide victims were from low income families.

Maltreatment

The FCCS child-death review process classifies each death into one of four categories following review of information obtained from public information sources and in-depth staffings of cases where the child was known to FCCS within a year of death. These four categories include:

1. Instances in which no maltreatment (either abuse or neglect factors contributing to the child's death) was ascertained.
2. Cases in which maltreatment was confirmed.
3. Cases in which maltreatment was suspected.
4. Cases in which cause of death (and thus maltreatment) was unknown.

The following definition was used when determining maltreatment:

A maltreatment death is defined as one in which, with retrospective analysis, it is determined that abuse and/or neglect factors contributed or were suspected to have contributed to the death resulting in a confirmed or suspected disposition. There may be instances where this cannot be ascertained by the reviewer, resulting in an unknown disposition.

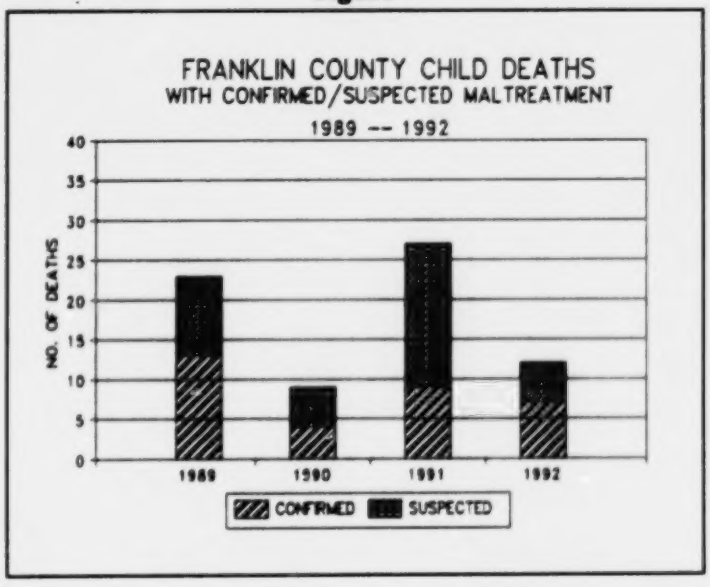
It should be noted that in order to be confirmed or suspected, the maltreatment must have been perpetrated by a parent or caretaker. Although one might assume that all homicide deaths should be categorized as maltreatment, we have taken the prerogative of categorizing them as no maltreatment **unless** they fit the conventional view of "maltreatment" associated with parent/caretaker-induced abuse or neglect resulting in the child death.

Confirmed and Suspected Maltreatment Deaths

- **Maltreatment was confirmed in 7 child deaths in 1992 (3%)—down from 9 (-22%) in 1991.**
- **Suspected maltreatment was found in 2% of the 1992 child deaths (5 out of the total of 207 deaths), down from 8% in 1991.**
- **The confirmed maltreatment deaths involved 3 homicides, two illnesses, 1 traffic accident, and 1 death from thermal injuries. The suspected maltreatments included 3 perinatal deaths, 1 illness, and 1 suicide.**

The following graph shows child deaths by category of maltreatment for 1989, 1990, 1991, and 1992.

Figure 7



Child Deaths Meeting Review Criteria

In 1992, FCCS again reviewed all deaths of children on its caseload at the time of death, as well as children who had been investigated or on "open case status" within a 12-month period prior to the death. Overall, 58 children (28%) of the 207 children who died in 1992 had some kind of contact with FCCS prior to death.

By comparison, 56 children (27%) of the total 206 child deaths in 1989, were at some time known to the Agency. In 1990, 45 children, or 18% of the total of 245 child deaths had some prior contact and in 1991, 59 children (27%) of the total 221 children had some contact prior to their death.

The following charts show deaths by type of FCCS contact for the years 1989 through 1992.

Figure 8

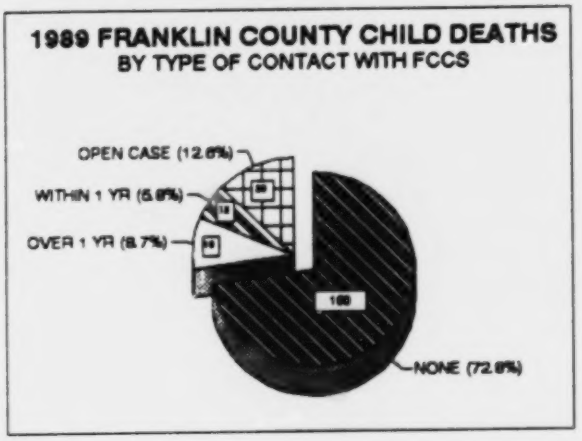


Figure 9

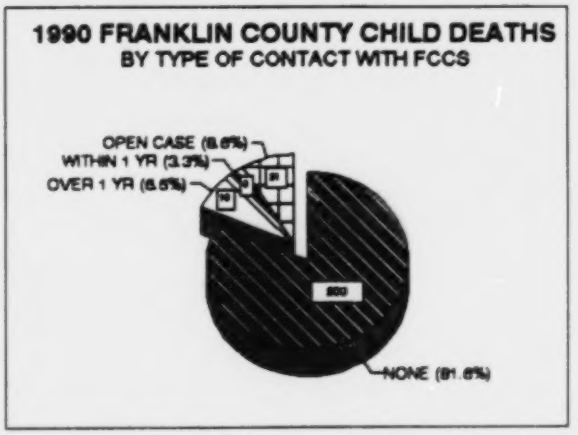


Figure 10

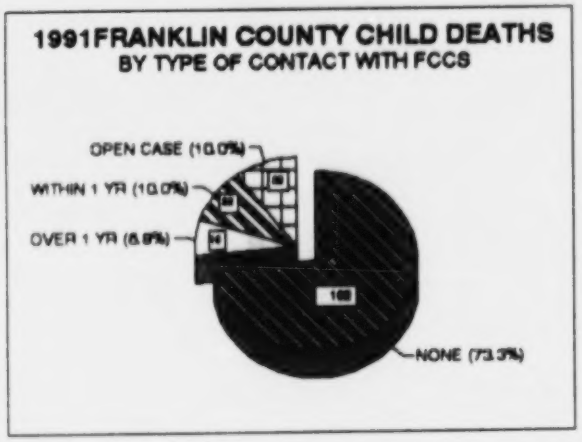
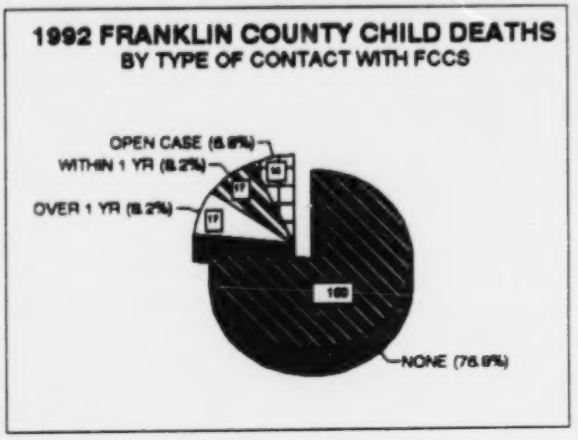


Figure 11



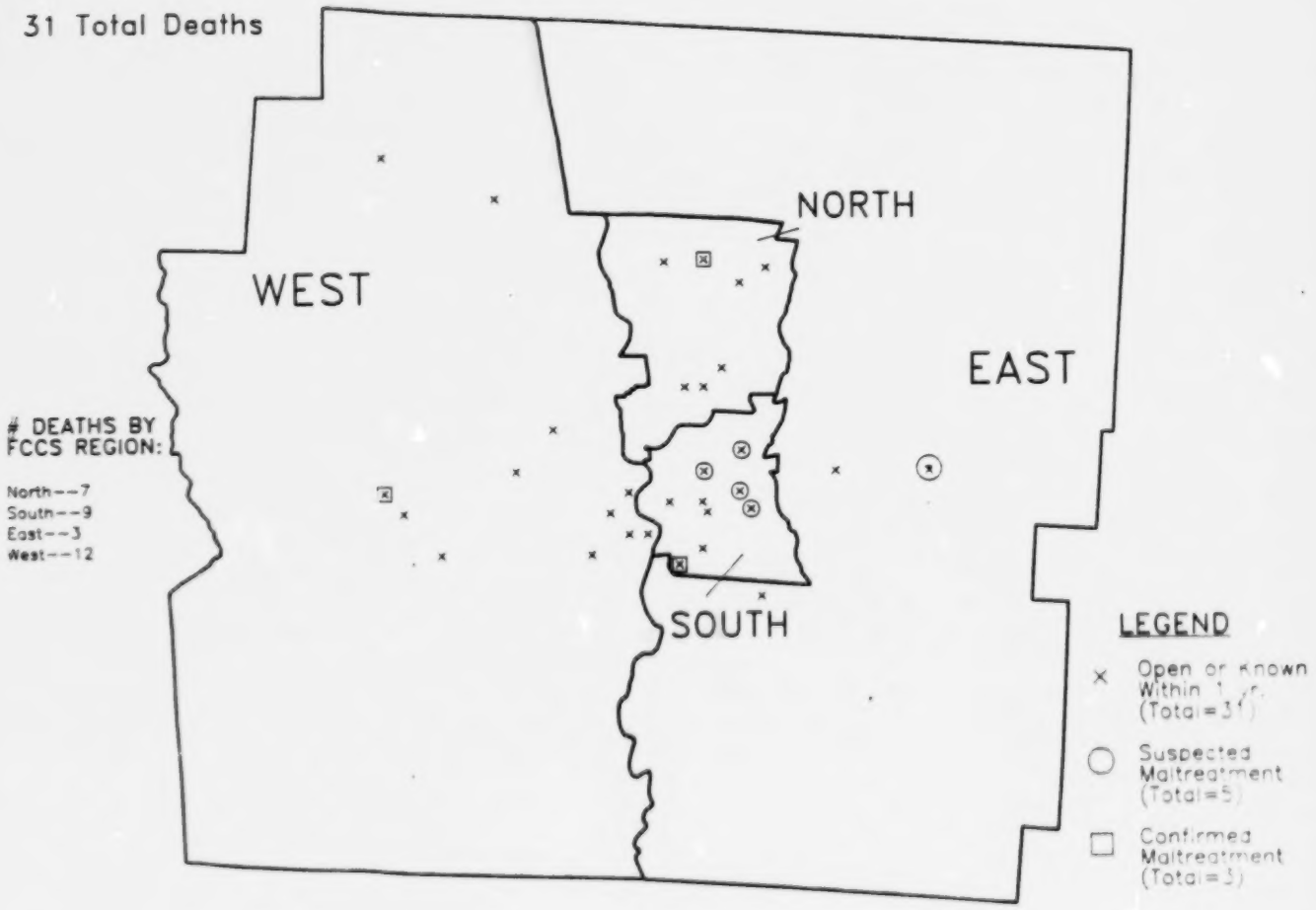
The number of children with whom FCCS has had direct contact has consistently risen since 1989. In 1992, FCCS had direct contact with 22,056 children compared with 19,504 in 1991 (a 13% increase). In 1990, the number of children having direct contact with FCCS totaled 16,915 and in 1989, 15,986.

Thirty-one of the total 207 child deaths in 1992 met the criteria for first level staffings. Eight of these deaths were formally staffed, involving all direct services providers to the child/family proximal to the death. These reports, resultant recommendations and responses received from the recommendations were reviewed by the County Team for further action. Case summary reports or record reviews were completed on the remaining 23 deaths. All of these deaths were discussed with the death certificate review sub-committee and additional information was collected. Recommendations resulting from these reviews were also shared with the County Team.

Thirteen of the children/families were receiving services from FCCS at the time of death; 18 were closed, but had received services within a year of death. Following is a map indicating where these children resided in the county.

GEOGRAPHIC DISTRIBUTION
1992 CHILD DEATHS

OPEN OR KNOWN TO FCCS WITHIN ONE YEAR OF DEATH
FRANKLIN COUNTY, OHIO



Findings by Cause of Death

Perinatal

- **10 perinatal deaths met the review criteria in 1992.**
- **9 were male and 1 was female.**
- **8 were Black and 2 were White.**
- **Age Range:**

All ten children were less than 28 days old.

Six of the deaths were determined to be low income eligible, all born prematurely between 22 and 26 weeks gestation. Four of the infants did not meet the criteria for low income eligibility, all four born prematurely between 24 and 34 weeks gestation. One of these infants also had a congenital heart defect present at birth. Mothers of seven of the 10 infants (six women) also had prior history of drug/alcohol abuse. Six of the infants dying from perinatal conditions resided within the inner city area encompassed by the FCCS North and South Regions.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Open Cases	2*	1	0	2
Closed Cases	1	2	1	1
Total	3	3	1	3

* Note: Although two of the open cases resided in the North Region geographic area, one of these cases was actually being served by South Region staff.

Five of the families were open to FCCS and five were closed (having prior involvement) at the time of death. As all of these infants died at or near birth, FCCS involvement related to older siblings in the family.

Three of the deaths were determined to have elements of suspected maltreatment. These included one infant with an underlying cause of maternal cocaine abuse (listed on the death certificate) contributing to a premature delivery, and two infants with mothers' having a history of drug/alcohol problems including prior births of drug affected infants. One of these mothers, suspected of being high, delivered at home and indicated that she was unaware she was in labor. The

other mother had a lengthy history of drug involvement and an older child had been drug affected at birth.

Seven of the remaining infants evidenced no elements of maltreatment.

Congenital

- **4 congenital deaths met the review criteria in 1992.**
- **3 were male and 1 was female.**
- **2 were Black and 2 were White.**
- **Age Range:**

0 to 6 months	0
6 to 12 months	0
1 to 5 years	1
5 to 10 years	2
12 to 14 years	0
14 to 18 years	1

Two of the child deaths were determined to meet the criteria for low income status including a 7 year-old dying from a congenital heart defect and a 2 year-old with brain stem dysfunction. The other two children died as a result of congenital problems related to cerebral palsy and aspiration resulting from probable seizure activity.

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Open Cases	0	1	0	1*
Closed Cases	0	0	0	2
Total	0	1	0	3

* Note: Although one of the children was residing in the West Region geographic area, services were being provided by South Region staff.

Two of the children were open to FCCS, one in a group home placement and the other in a hospice facility resulting from their family's inability to continue caring

for them due to their physical problems. The remaining two were closed at the time of death.

None of these four deaths was the result of maltreatment.

Sudden Infant Death Syndrome

- **3 SIDS deaths met the review criteria in 1992.**
- **2 were male and 1 was female.**
- **3 were White**
- **Age Range:**

> 1 month	1
1 to 3 months	1
3 to 6 months	1

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Open Cases	0	0	0	0
Closed Cases	0	0	0	3
Total	0	0	0	3

All three children meeting the review criteria with SIDS as a cause of death had prior contact with FCCS and were closed at the time of their deaths. One child was born to a minor mother who had been investigated regarding abuse allegations (unsubstantiated) about another child. Services had been provided to the other two mothers as a result of neglect concerns regarding older siblings. Both cases were closed after successful provision of services.

All three children were autopsied, and SIDS was the medically confirmed cause of death. None of the deaths was determined to have elements of maltreatment, and all three met the criteria for low income status.

Illness

- **5 death resulting from illness met the criteria for review.**
- **4 were male and 1 was female.**
- **3 were Black and 2 were White.**
- **Age Range:**

< 1 year	4
1 to 5 years	0
5 to 10 years	1

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Open Cases	1	3*	0	0
Closed Cases	0	1	0	0
Total	1	4	0	0

* Note: Although three of these families resided in the South Region geographic area, one was being investigated by the Intake department due to neglect allegations, one was being served by North Region staff; and one was being served by East Region staff.

Three of the children were open to FCCS and two were closed at the time of death. One of the children was receiving services as a result of testing positive for cocaine at birth. The mother of this child had received no prenatal care.

Another child was receiving services due to a substantiated neglect complaint regarding an older sibling. Two other children had previously died in this family, one of SIDS (age 15 months) and one of pneumonia (1 day). The third child, who eventually died of leukemia, was receiving services due to a substantiated neglect complaint regarding parental inability to provide care due to intoxication.

Two children were not receiving services at the time of their deaths, but both had prior FCCS contact via complaints. One was born prematurely at 29 weeks, the mother received only two prenatal visits and reported use of alcohol and tobacco during pregnancy. The presenting complaint was that the child had received inadequate follow-up medical care after birth. Linkage with medical providers was made, but the child died approximately 30 days later. The remaining child

was not receiving services at the time of death, but two prior complaints related to a sibling had been investigated and unsubstantiated.

Two of the children met the criteria for low income status. All five of these children resided within the inner city area encompassed by the FCCS North and South Regions.

Three of the deaths had no elements of maltreatment present. One was determined to have elements of suspected maltreatment due to the mother's drug use prior to delivery and lack of prenatal care. This infant subsequently tested positive for cocaine at birth. Another death was confirmed to have elements of maltreatment due to the parent's lack of follow-through with medical care after the child's birth.

Unintentional Injury

- **Eight unintentional injury deaths met the criteria for review.**
- **All eight were males.**
- **Seven were White and one was Black.**
- **Age Range:**

> 1 year	0
1 to 5 years	3
5 to 10 years	1
10 to 14 years	1
14 to 18 years	3

Geographic Location of Deaths by Region				
	North	**South**	**East**	**West**
Open Cases	1	0	0	2
Closed Cases	2	1	1	1
Total	3	1	1	3

Causes of Unintentional Injury Deaths:

- **2 traffic/pedestrian**
- **2 auto accidents**
- **2 aspiration/choking**
- **1 thermal injury**
- **1 electrocution**

Three of the children were open and receiving services while five were closed at the time of death. Of the open cases, one was open as a result of scalding burns from which the child later died. Neglect had been substantiated due to the mother's lack of supervision of this 14-month-old child who was developmentally delayed. Another 17-year-old child, who died of electrocution while working on an appliance, was open as a result of behavioral, drug and alcohol problems. The third, an 11-year-old child killed in a pedestrian/traffic accident, was open as a result of longstanding difficulties exhibited by the parents in caring for their children without assistance.

Maltreatment was confirmed in two of the deaths, including the child scalded and a 3-year-old run over by another child when both were left unsupervised in a running vehicle. Maltreatment could not be determined for one of the deaths involving a three year old child dying as a result of aspiration of gastric contents. There was no evidence of maltreatment in the five remaining deaths.

Three of the unintentional injury deaths met the criteria for low-income status.

Suicide

- **One suicide met the criteria for review.**

- **White female, age 13 years.**

Geographic Location of Death by Region				
	North	**South**	**East**	**West**
Closed Case	0	0	1	0

This child was not open at the time of death; however, she had previously received services due to parent-child conflict and identified mental health problems. This death was determined to have elements of suspected maltreatment due to a history of questionable follow-through of recommended services.

This child was identified as meeting the criteria for low-income status.

Maltreatment

Maltreatment was confirmed in three of the 31 deaths meeting the review criteria. These included two unintentional injuries (a child scalded in the bathtub by a sibling and a child run over by another child when both were left unattended in a running vehicle) and one illness (an infant who died of bronchiolitis who had not received adequate ongoing medical care after birth). Of these deaths, only one was open at the time of death. A case had been opened on behalf of the child as a result of his injuries (which subsequently led to his death). Another infant, although closed, died of bronchiolitis in the home of caretakers who were under investigation regarding neglect allegations related to her own children. The three confirmed maltreatment children were three years of age or under (3 years, 14 months and 6 months). All three were male and White.

Maltreatment was suspected in five additional deaths. These deaths included three resulting from perinatal conditions, one from illness and one from suicide. The three perinatal deaths were all infants born prematurely (20 to 24 weeks gestation) who died within hours of birth. Two of the infants' mothers received no prenatal care, and all three had a history of drug/alcohol abuse which had been unresolved. An older sibling of one of the infants had tested positive for cocaine at birth. Due to the extreme prematurity of these infants, none was tested for drugs.

Another infant, who died of illness at 18 days, also met the criteria for suspected maltreatment. This child did test positive for cocaine at birth and his mother had received no prenatal care. This mother also has a long history of unresolved drug/alcohol abuse.

The fifth suspected maltreatment death involved the suicide of a 13-year-old who had a history of parent/child conflict and prior psychiatric hospitalizations. There was concern that the mother had not followed through with recommended treatment for this child.

Of the children in this category, four were Black males and one was a White female. Two met the criteria for low-income status, and all four of the infants resided within the inner-city South Region area. Two of the families were open to FCCS as services were being provided to older siblings who resided with relatives. Three were closed but had received services within the last year.

Confirmed and Suspected Maltreatment Deaths

- **Maltreatment was confirmed in 3 child deaths meeting the review criteria in 1992 (10%)—down from 6 (-50%) in 1991.**

- **Suspected maltreatment was found in 16% of the 1992 child deaths (5 of the 31 deaths meeting the review criteria), down from 11 (-55%) in 1991.**

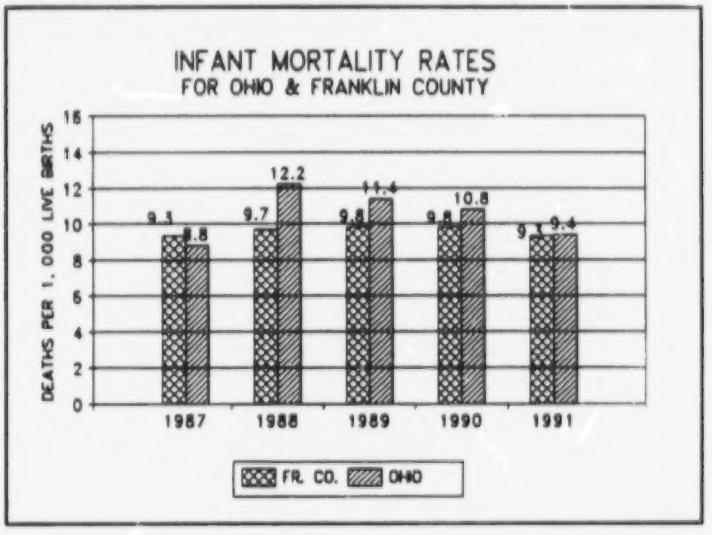
As noted in previous reports, higher maltreatment figures for children known to FCCS are not surprising inasmuch as FCCS typically serves families whose children are at a much higher-than-average risk of maltreatment or death. Also, FCCS could much more easily discern possible maltreatment factors—especially neglect factors—in those cases in which the agency had contact with the deceased child.

Review of cases with which FCCS had contact also benefitted from a wealth of detailed information available from other community agency staff who attended deceased child case staffings. In cases where a deceased child was not known to FCCS, information regarding factors of maltreatment associated with the death was usually unavailable unless the death was notable and covered in newspaper articles (homicides). Thus, for most "no maltreatment" cases, information about the circumstances surrounding the death was limited. Had more been known, some of these deaths might well have been classified into one of the other two maltreatment categories.

Conclusions

Again, as in the past three years, the largest proportion of child deaths occurred as a result of perinatal conditions and congenital defects. The majority of these children died prior to six months of age which is also comparable with data from the three previous years. This information is consistent with that of the Columbus Health Department which indicates that, although slightly decreasing, the infant mortality rate has not significantly declined. The 1991 Franklin County infant mortality rate, as reported by the Columbus Health Department, was 9.3 deaths per 1000 live births (Figure 12). The county's White rate was 7.8 while the Black rate continued to be nearly double that at 14.4 deaths per 1000 live births.

Figure 12



Infant mortality (babies dying before their first birthday) is generally considered as a quality-of-life indicator of both the health and welfare of a community. A high rate indicates not only unmet health needs, but also conditions such as poverty, poor nutritional status, lack of education, high rate of unintended pregnancy and changes in maternal characteristics such as drug use (Columbus Health Department, 2-93).

The international infant mortality rate shown in the table below indicates the United States rank among the more industrialized, wealthier nations of the world. The U.S. infant mortality rate in 1989 was 10 deaths per 1000 live births ranking 20th among other nations. The United States ranks poorly among industrialized nations on other maternal and child health indicators as well:

- higher rates of unintended pregnancies, especially among teens;
- lower immunization rates among children; and
- lower rates of participation of pregnant women in prenatal care.

Possible strategies to reduce infant mortality could come from modeling other nations who have been more successful in reducing infant deaths. These strategies include no financial barriers to prenatal care, extensive use of nurse practitioners and/or midwives, home visitation program for all infants or for those infants weighing less than 2500 grams at birth and greater access to low or no cost family planning services.

Efforts to reduce infant mortality in this community occur via the Franklin County Leadership Council to Reduce Infant Mortality, which was founded in March 1992. The mission of the Council is to reduce infant mortality to 7 deaths per 1,000 live births by the year 2000. This effort is being accomplished via collaborative task teams where problems are identified and resolutions sought.

The Alcohol, Drug Addiction and Mental Health Board of Franklin County has also evaluated the need for alcohol/drug day treatment and intensive outpatient services for women. This certainly recognizes the numbers of women who are substance abusing prenatally and not receiving adequate, if any, prenatal care.

INFANT MORTALITY RATES* SELECTED COUNTRIES, 1990

Rank	Nation	Rate/1000 Live Births
1	Japan	5
2	Finland	6
2	Sweden	6
4	Canada	7
4	Germany	7
4	Hong Kong	7
4	Switzerland	7
4	Netherlands	7
9	Australia	8
9	Austria	8
9	Belgium	8
9	Denmark	8
9	France	8
9	Ireland	8
9	Norway	8
9	Singapore	8
9	Spain	8
9	United Kingdom	8
10	Italy	9
20	**United States**	**10**
24	Cuba	11
26	Portugal	13
27	Bulgaria	14
30	Jamaica	16
33	Costa Rica	18
	U.S. Black	**18**

*Infant deaths per 1000 live births.
Source: Children's Defense Fund's The Health of America's Children, 1992, and UNICEF, State of the World's Children.
**U.S. data are 1989 from NCHS.

Again, as in years past, the second leading cause of death was attributed to Sudden Infant Death Syndrome, with 31 (15%). Although this number is consistent with national averages, we must assure that research and investigation continue to determine risk factors and why these deaths occur.

Sixty-seven (32%) deaths including illness, unintentional injury, homicide and suicide can all categorized as clearly preventable. These preventable deaths comprise nearly one-third of the total county child deaths and impacting this group could substantially decrease the death rate. The Central Ohio Safe Kids Coalition, consisting of a loose network of organizations concerned with safety issues, is focusing their efforts on prevention of injuries and deaths via community education and campaigns like "Please Be Seated." This campaign focuses on the need for increased use of car restraint systems for infants and children under four years of age.

Action Planning 1993

Although it is difficult to evaluate trends with four years of data, the number of infant deaths occurring in the perinatal period has remained consistently high with slight decreases in the infant mortality rate. Preventable child deaths at 33% of the total are significant concern and also require some action.

The following areas are targeted for action in 1993:

- Assure the availability of prenatal care for all women which includes the following components; 1) early and continuing risk assessment; 2) health promotion; and 3) medical, nutritional, and psychosocial interventions and follow-up (Source: **Healthy People 2000: National Health Promotion and Disease Prevention Objectives**, U.S. Department of Health and Human Services, U.S. Public Health Service, 1990);

- Continue collaboration by involved systems and agencies to provide a more comprehensive system of care for at-risk pregnant women with substance abuse issues;

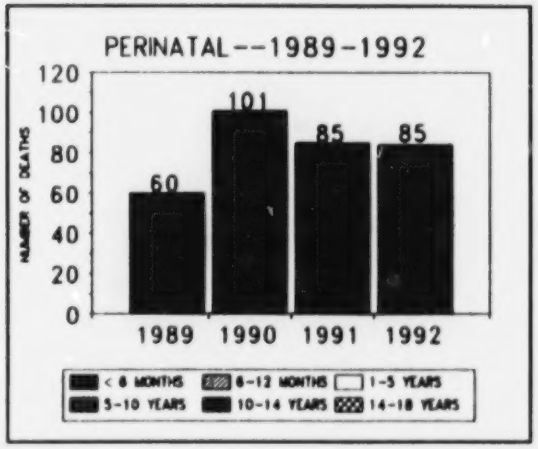
- Institute and expand outreach and lay home visiting programs to pregnant women, particularly in the central city area;

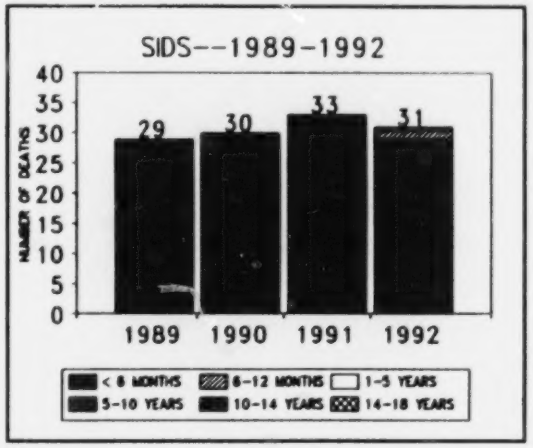
- Develop and/or expand community-based programs to provide the services necessary to assure healthy pregnancy outcomes and childhoods for all children in these communities;

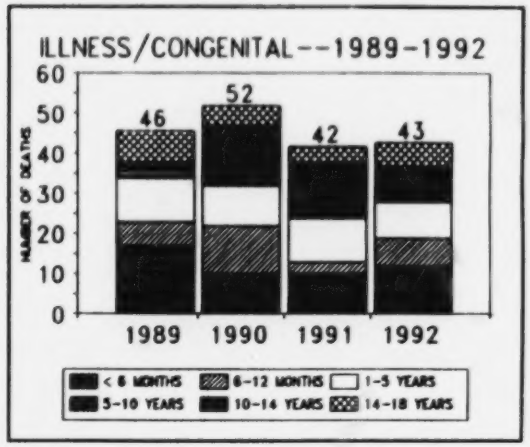
- Promote the expansion of women and child health services and issues through legislative advocacy; and

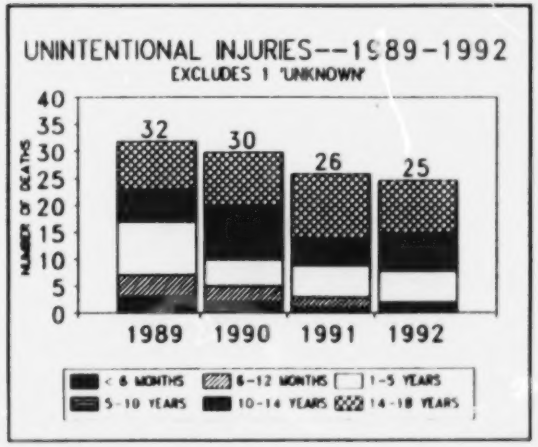
- Institutionalize efforts geared at the elimination of preventable childhood injury and death in currently operating systems and programs.

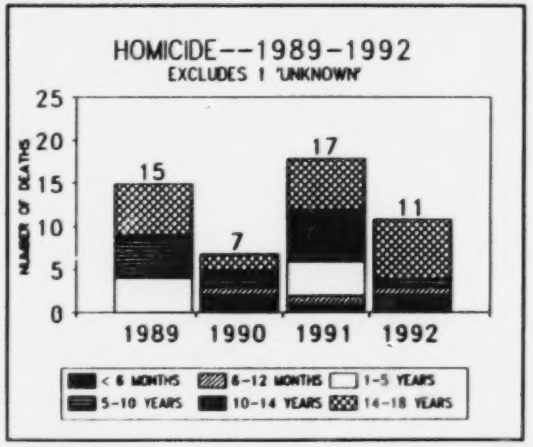
Appendix A: Cause of Death by Age of Child

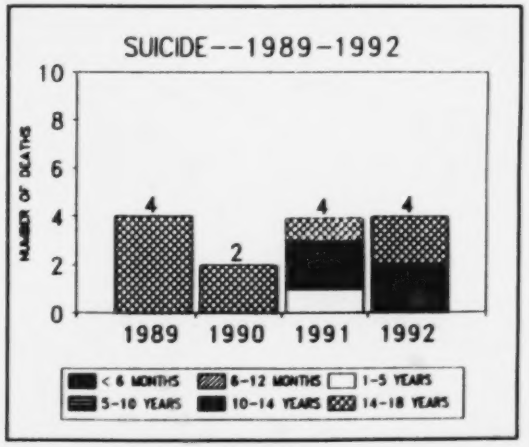




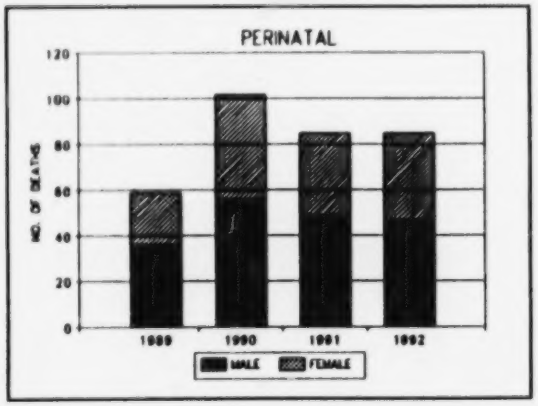


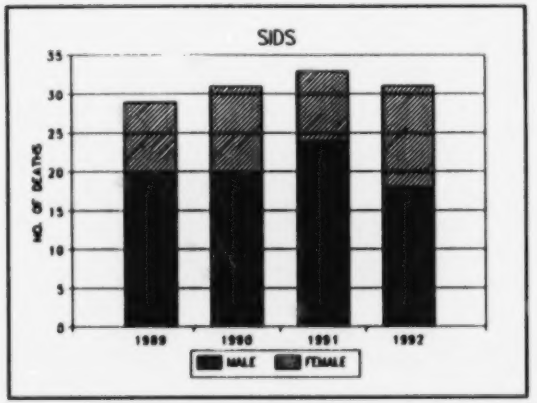


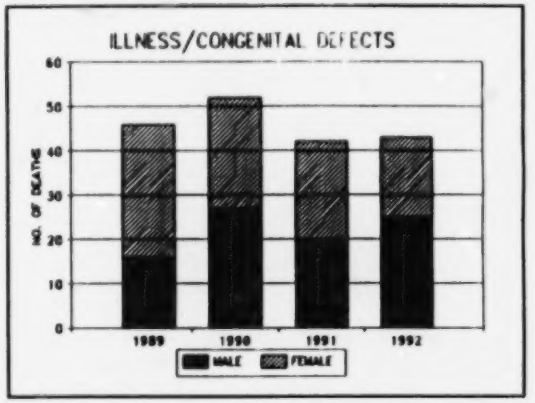


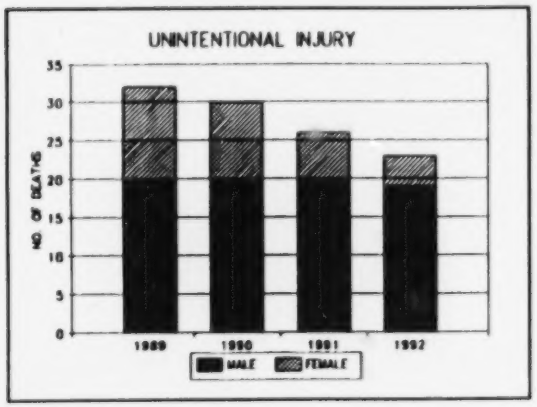


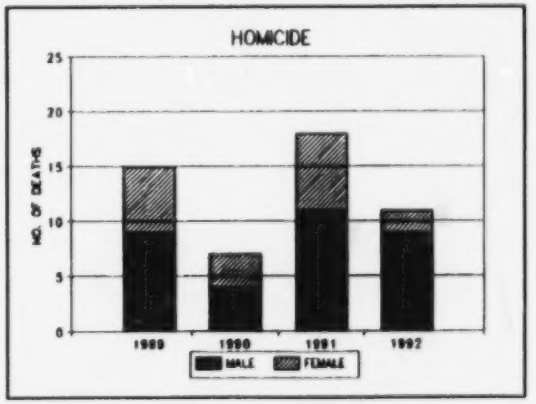
Appendix B: Cause of Death by Sex of Child

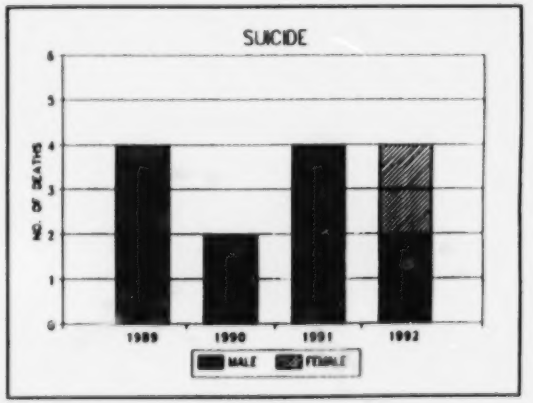




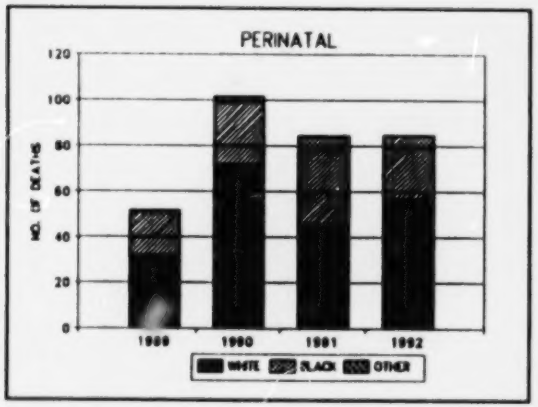


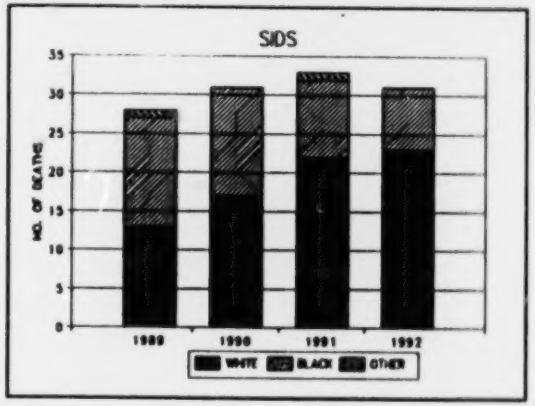


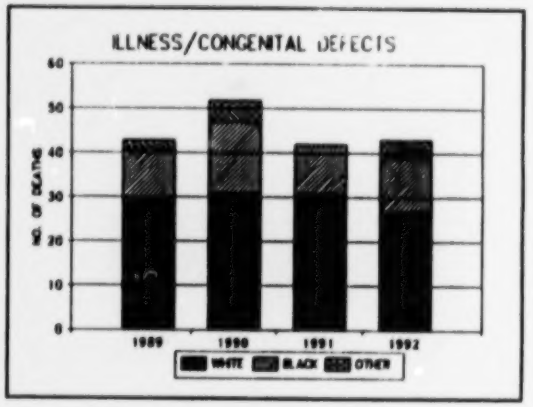


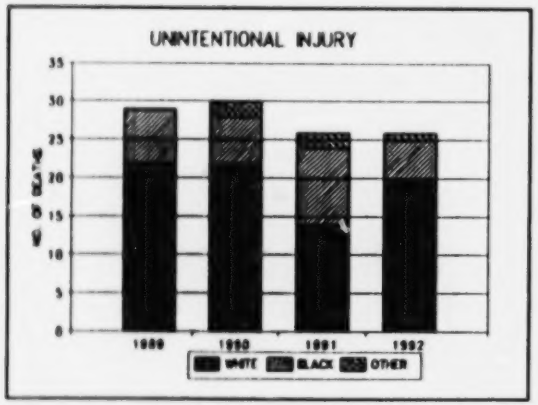


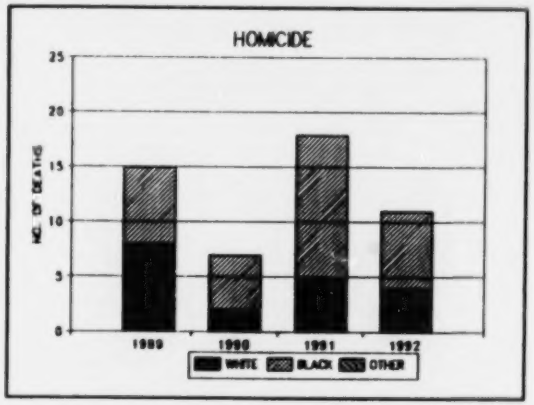
Appendix C: Cause of Death by Race of Child

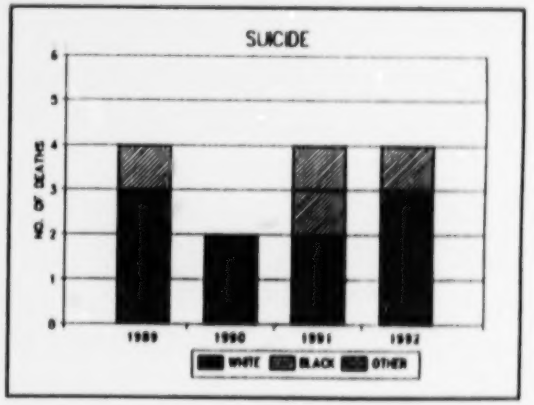




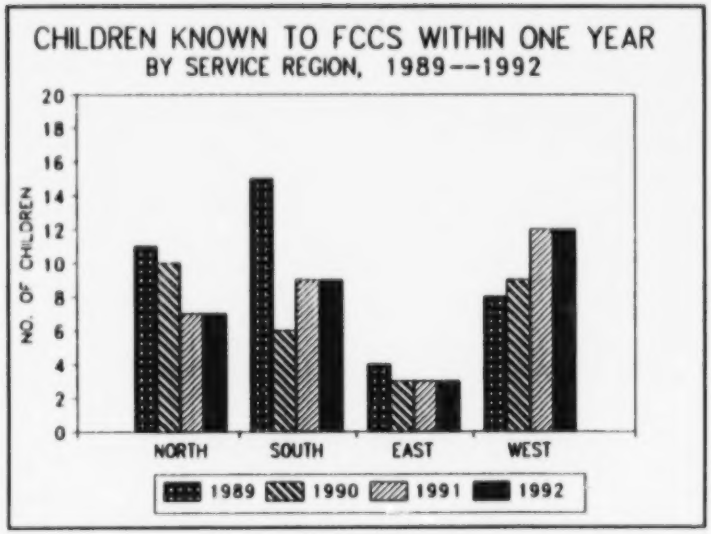


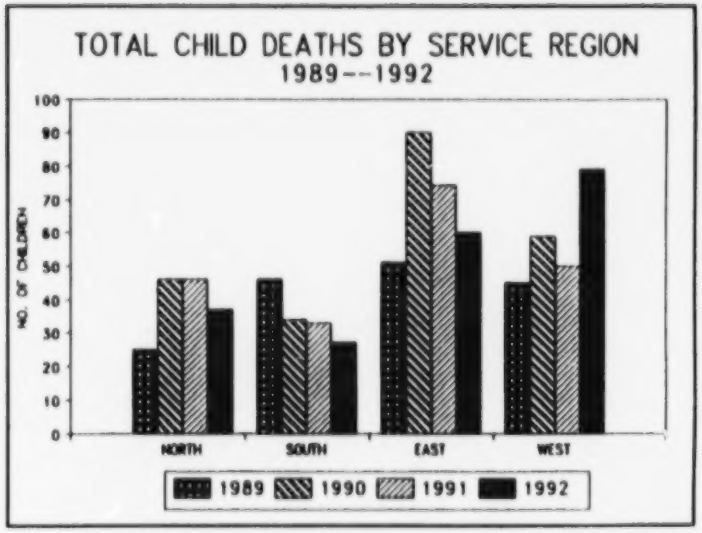




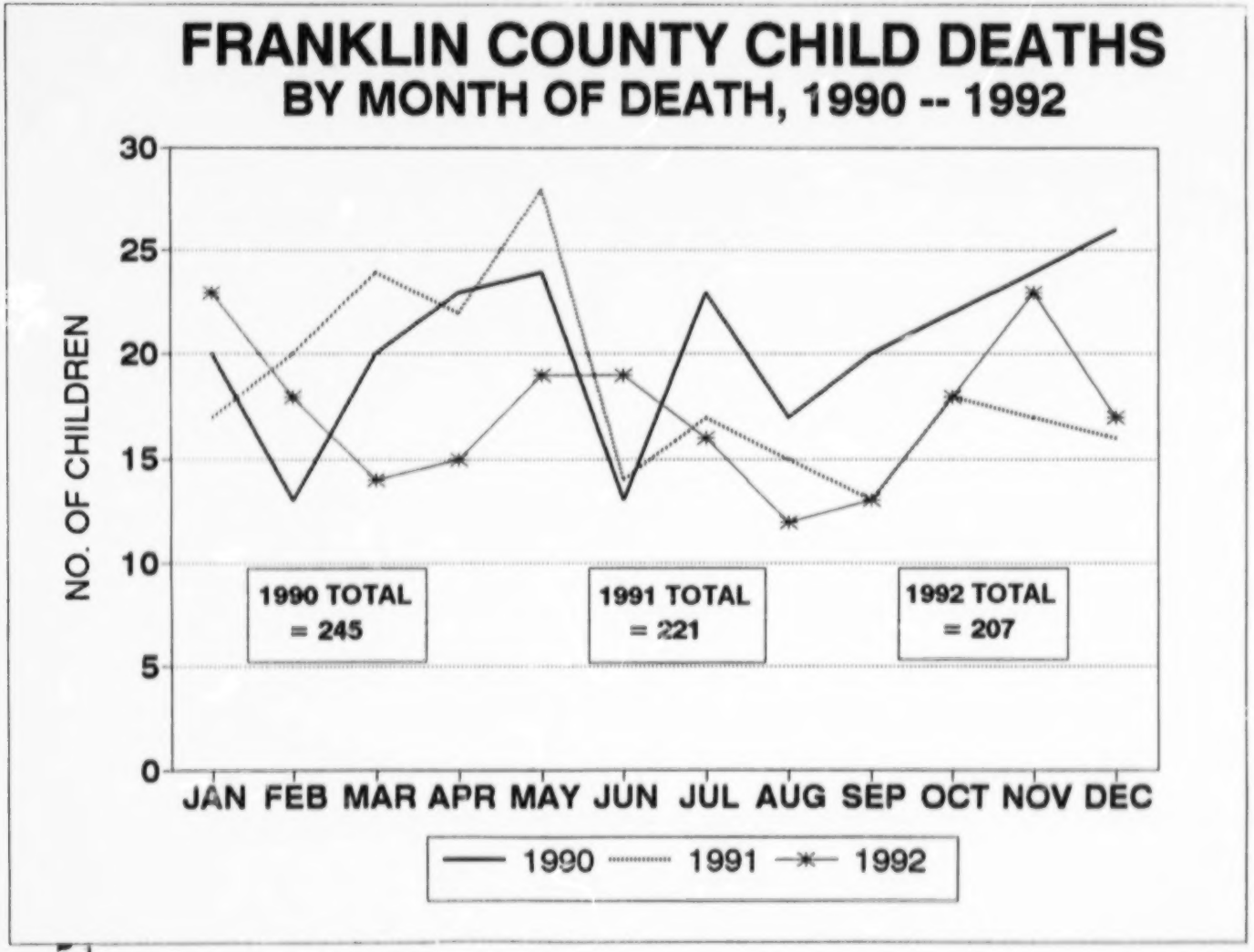


Appendix D: Child Deaths By Region





Appendix E: Child Deaths By Month



Appendix F: The Review Process

The Franklin County Deceased Child Review System was developed as a collaborative, multi-disciplinary effort which incorporates fact-finding, data collection and a systems analysis/change process which involves the following four components:

FCCS Deceased Child Case Staffings

Purpose

To identify weaknesses in practice, standards, programs and systems which, if corrected, would improve service delivery and prevent deaths of the type reviewed. This review process is also used to affirm practice, program and system strengths which currently protect children from death.

Process

Case summary reports are completed on all child deaths which occur on open FCCS cases, and case record reviews are completed on closed cases where families/children had been served within one year of the death. Staffings may then be held which involve staff from all community agencies and persons involved with the children and families before or immediately following the death. These staffings also include a randomly-selected three-person impartial panel representing all levels of staff within FCCS. An acknowledgement of confidentiality is signed by all parties attending the review in compliance with state laws and the Ohio Department of Human Services rules. Staffings are not held when a child is born prematurely, there are no indications of inadequate prenatal care and the death is deemed unpreventable by a physician; or when death occurs as a result of chronic disease, no case is open and a physician confirms life could not have been extended.

Case summary reports and record reviews include:

a. the circumstances surrounding the death, a case history profile, and involvement of significant participants;

b. an evaluation of compliance with applicable regulatory and practice standards and with FCCS policy and procedure; and,

c. any recommendations for modifications of procedures, policies or programs internally to FCCS and externally with other community agencies in an effort to reduce and/or eliminate future child deaths through improved services to at-risk children.

NOTE: This review process is completely separated from any disciplinary

investigation process which is conducted when necessary under existing FCCS protocols.

Database Establishment

Purpose

To determine the total number and causes of child deaths in Franklin County and to provide a detailed analysis including various demographic factors. To identify the number of deaths which involve elements of confirmed or suspected maltreatment or are otherwise preventable.

Process

Establishment of a comprehensive database on child deaths using data gathered from a variety of sources. The database is maintained by the coordinating agency (FCCS) and all data is kept confidential.

County-Level Deceased Child Reviews

Purpose

To review cases of child deaths in the county with a focus on evaluating the maltreatment and preventability of the death. The County Team focuses on the recommended inter-system program changes resulting from FCCS Deceased Child Case Staffings and acts as an informed coalition of professionals to provide influence and raise support for the implementation of key child death prevention initiatives.

Process

A county team composed of representatives from various child-serving agencies reviews aggregate and anonymous data regarding child deaths in order to act upon previously made staffing recommendations and to develop its own recommendations geared towards the ultimate reduction of preventable child deaths in the county.

Community Education

Purpose

To develop community-wide understanding of the nature of child deaths occurring in the county. To build community support for the efforts of the County Deceased Child Review Team in their goal of eliminating preventable child deaths in Franklin County.

Process

The County Deceased Child Review team maintains an ongoing dialogue with the community via educational and community awareness activities. This dialogue occurs informally via the various agencies' involvement with the review process and through the annual completion of a report which is released to the community.

Appendix G: About Franklin County Children Services

Services, Funding, and Organization

Franklin County Children Services (FCCS) in Columbus, Ohio, is the public, county-wide agency responsible for the **care and protection of abused, neglected, dependent and troubled children.** In 1992, 25,641 children and families were served through a Children Services tax levy that supports the operations of FCCS and the purchase of services from 55 community agencies. FCCS provides a comprehensive array of services, including:

- a 24-hour hotline to report abuse and neglect of children;
- investigation of child maltreatment and crisis intervention for children in need;
- protective in-home counseling and supportive services to children and families;
- placement in out-of-home care for children in need of temporary foster home care, permanent adoptive homes or independent living situations;
- prevention programs for high-risk children and families; and
- services to children with medical handicaps.

In 1992, FCCS's expenditures were $61,907,872. Of that amount $26,789,680 was spent to provide placement away from home for children in need; $27,312,256 was spent to provide protective in-home services to children living with their families; $5,300,949 was spent to investigate suspected child maltreatment; $1,103,504 was spent to provide prevention services to keep children off the FCCS caseload; and, $1,205,614 was spent to provide services to children with medical handicaps. The 1992 Income was $64.8 million of which about 74 percent was from local property taxes, 19 percent Federal and 5.5 percent from the State.

FCCS is governed by an 11-member board, employs 768 persons, and is regulated by mandates of the state and federal government, and fully accredited by the Council on Accreditation of Services for Families and Children. FCCS is one of five County Children Services Boards in Ohio to be accredited as members of the Child Welfare League of America.

FCCS Client Demographics

As of April 1993, FCCS had 5,956 children from 3,037 families open and receiving services. Fifty-one percent of these children are African-American, and 35.2 percent are age five and under.

In the first three months of 1993, there were 2,229 investigations of neglect and abuse completed. This compares to 2,337 investigations during the same time frame for 1992, a 5 percent decrease. Referrals decreased by 4 percent; consequently, investigations decreased by 4 percent.

Case openings for neglect are 29 percent lower in 1993 than in 1992, and for abuse are 33 percent lower in the same time frame.

Compared to 1992, the number of children coming into substitute care is holding stable. But the number of very young children coming into care is increasing. Entrances into foster home care have increased by 37 percent while placements into purchased institutions have decreased 10 percent.